SERFF Tracking Number:	*UHLC-127378273*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*49598*
Company Tracking Number:	*MHPAMD.H.09.AR_REV1*		
TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02G.003C Large Group Only - HMO*
Product Name:	*MHPAMD.H.09.AR_REV1*		
Project Name/Number:	*MHPAMD.H.09.AR_REV1/MHPAMD.H.09.AR_REV1*		

Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.

Product Name: MHPAMD.H.09.AR_REV1	SERFF Tr Num: UHLC-127378273	State: Arkansas
TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)	SERFF Status: Closed-Approved-Closed	State Tr Num: 49598
Sub-TOI: HOrg02G.003C Large Group Only - HMO	Co Tr Num: MHPAMD.H.09.AR_REV1	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Kelly Smith	Disposition Date: 08/19/2011
	Date Submitted: 08/19/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: MHPAMD.H.09.AR_REV1	Status of Filing in Domicile: Not Filed
Project Number: MHPAMD.H.09.AR_REV1	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 08/19/2011	
State Status Changed: 08/19/2011	Deemer Date:
Created By: Kelly Smith	Submitted By: Kelly Smith

Corresponding Filing Tracking Number: MHPAMD.H.09.AR_REV1
PPACA: Not PPACA-Related
PPACA Notes: null
Filing Description:
Hearing Aid, Autism Spectrum Disorder, Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Amendment against the 2009 COC POL.H.09.AR

Company and Contact

SERFF Tracking Number:	*UHLC-127378273*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*49598*
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TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02G.003C Large Group Only - HMO*
Product Name:	*MHPAMD.H.09.AR_REV1*		
Project Name/Number:	*MHPAMD.H.09.AR_REV1/MHPAMD.H.09.AR_REV1*		

Filing Contact Information

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(952) 992-7428 ext. [Phone]

CoCode: 95446
Group Code:
Group Name:
FEIN Number: 63-1036819

State of Domicile: Arkansas
Company Type: HMO
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	$50.00	08/19/2011	50785143

SERFF Tracking Number:	*UHLC-127378273*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*49598*
Company Tracking Number:	*MHPAMD.H.09.AR_REV1*		
TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02G.003C Large Group Only - HMO*
Product Name:	*MHPAMD.H.09.AR_REV1*		
Project Name/Number:	*MHPAMD.H.09.AR_REV1/MHPAMD.H.09.AR_REV1*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/19/2011	08/19/2011

SERFF Tracking Number:	*UHLC-127378273*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*49598*
Company Tracking Number:	*MHPAMD.H.09.AR_REV1*		
TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02G.003C Large Group Only - HMO*
Product Name:	*MHPAMD.H.09.AR_REV1*		
Project Name/Number:	*MHPAMD.H.09.AR_REV1/MHPAMD.H.09.AR_REV1*		

Disposition

Disposition Date: 08/19/2011
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-127378273*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*49598*
Company Tracking Number:	*MHPAMD.H.09.AR_REV1*		
TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02G.003C Large Group Only - HMO*
Product Name:	*MHPAMD.H.09.AR_REV1*		
Project Name/Number:	*MHPAMD.H.09.AR_REV1/MHPAMD.H.09.AR_REV1*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	MHPAMD.H.09.AR_REV1	Approved-Closed	Yes

SERFF Tracking Number:	*UHLC-127378273*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*49598*
Company Tracking Number:	*MHPAMD.H.09.AR_REV1*		
TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02G.003C Large Group Only - HMO*
Product Name:	*MHPAMD.H.09.AR_REV1*		
Project Name/Number:	*MHPAMD.H.09.AR_REV1/MHPAMD.H.09.AR_REV1*		

Form Schedule

Lead Form Number: MHPAMD.H.09.AR_REV1

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/19/2011	MHPAMD.H.09.AR_REV1	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	MHPAMD.H.09.AR_REV1	Revised	Replaced Form #: MHPAMD.H.09.AR_REV1 Previous Filing #: MHPAMD.H.09.AR	50.400	MHPAMD.H.09.AR_REV1.pdf

Hearing Aid, Autism Spectrum Disorder, Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Amendment

UnitedHealthcare of Arkansas, Inc. [[1]and UnitedHealthcare Insurance Company]

As described in this Amendment, the Policy is modified as stated below.

Contract Issuance: *Include only if the Amendment is to be mailed separate from the COC and if the 2009 series is modified by other amendments. Do not include when amendment is issued as part of the COC.*

[Because this Amendment reflects changes in requirements of Federal law, to the extent it may conflict with any Amendment issued to you previously, the provisions of this Amendment will govern.]

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Amendment below.

For Choice, do not include any of the pre-service benefit confirmation provisions below other than the first sentence.

Prior authorization requirements listed under *[Mental Health Services] [and] [Substance Use Disorder Services]* in the *Schedule of Benefits* are deleted. [The following [services are] [service is] added to the list of services requiring pre-service notification under *Pre-service Benefit Confirmation* in the *Schedule of Benefits:*

[Pre-service Benefit Confirmation]

[When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying us before you receive these services.

To notify us, call the telephone number for *Customer Care* on your ID card.

Covered Health Services which require pre-service notification:

- [Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.]
- [Neurobiological Disorders - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), intensive outpatient program treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home; [Applied Behavioral Analysis (ABA).]]
- [Autism Spectrum Disorders - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), intensive outpatient program treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with

or without medication management; outpatient treatment provided in your home; [Applied Behavioral Analysis (ABA).]]

- [Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; psychological testing; outpatient treatment of opioid dependence; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.]]

Include when COC was issued to a group including a hearing aid benefit or when the COC was approved with non-variable language supporting a hearing aid mandate.

[Hearing Aids in the *Certificate*, *Section 1: Covered Health Services* is deleted and replaced with the following Covered Health Service description:]

Include when COC was issued to a group that did not include a hearing aid benefit.

[The following Covered Health Service description for *Hearing Aids* is added to the *Certificate*, *Section 1: Covered Health Services*:]

Note: The bracketed covered health service number here and in the schedule will not be included when the document is issued in amendment format only; including it will be used only to support accurately embedding amendment provisions into the COC or Schedule where permitted. Include as standard for groups of 2 to 15 and 15+.

[9.] Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in the *Certificate*, only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Include when COC was issued to a group including a hearing aid benefit or when the COC was filed with language supporting a hearing aid mandate.

[*Hearing Aids* in the *Schedule of Benefits* is deleted and replaced with the following Covered Health Service description:]

Include when COC was issued to a group that did not include a hearing aid benefit.

[The following Covered Health Service description for *Hearing Aids* is added to the *Schedule of Benefits*:]

[1]Include for Choice Plus. [2]Include for Choice. ***[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]*** ***[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]***			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[1]Include Network and Non-Network references for Choice Plus; delete references and the Non-Network row for Choice. **[9.] Hearing Aids**			
Include the limit selected by the group. *Limit must be the same as annual limits selected for Durable Medical Equipment and Prosthetics, or $5,000 per year if DME and Prosthetic limits exceed $5,000 per year.* [Limited to $[2,800 - 5,000] in Eligible Expenses per year, but shall at least be $1,400 per ear. Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-three] years].] No Copayment, Coinsurance or Deductible will be applicable to Hearing Aid Coverage	***[[1]Network]*** [[50 - 100]%] ***[[1]Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

***[Mental Health Services [,] [and] [Neurobiological Disorders] [Autism Spectrum Disorder Services]* [and] *[Substance Use Disorder Services]* in the *Certificate, Section 1: Covered Health Services* [is] [are] deleted and replaced with the following:**

Note: The bracketed covered health service numbers here and in the schedule will not be included when the document is issued in amendment format only; including it will be used only to support accurately embedding amendment provisions into the COC or Schedule where permitted.

Include when group purchases plan with MH benefits.

[#] [Mental Health Services]

[Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

Include when group purchases plan with benefits for autism spectrum disorders. When Mental Health Benefits are included, core autism benefits will always be included because medical benefits for autism treatment are paid under the medical plan based on place of service (parity issue).

Contract Specialist: Use this section to support mental health components of state mandates for autism. If the mandate includes other medical benefits, the separate mandate section should address only the medical components and refer back to this section for mental health benefits for autism disorders. Delete this instruction prior to filing.

[#] [Neurobiological Disorders] [and,] [Autism Spectrum Disorder Services]

[Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

Note to contract specialist: [1]Include when no autism specific benefit has been added per state law. [2]Include and modify coverage section title accordingly when state law requires a specific benefit be included. (Note that when a specific medical/rehab benefit is required for autism, you should also refer back to this category for the psychiatric component.) Delete this instruction prior to filing.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available [[1]under the applicable medical Covered Health Services categories in this *Certificate*] [[2]as described under [autism benefit section name] below]. Services limited to children under eighteen (18) years of age.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

Include when expanded services for autism are sold.

Note to contract specialist: This section should be utilized to support the mental health component of state mandates for autism spectrum disorders for intensive behavioral therapies such as ABA. Delete this instruction prior to filing.

[Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).]

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.]

Include when group purchases plan with SUD benefits.

[#] [Substance Use Disorder Services]

[Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.

- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

[Mental Health Services [,] [and] [Neurobiological Disorders] [Autism Spectrum Disorder Services] [and] *[Substance Use Disorder Services]* in the *Schedule of Benefits* [is] [are] deleted and replaced with the following:

[1]Include for Choice Plus. [2]Include for Choice.

[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]

[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Include for groups that purchase mental health benefits. **[#.] [Mental Health Services]**			

Do not include Pre-Service Notification Requirement for Choice.

[Pre-Service Notification Requirement]

[For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), you must notify us prior to the admission, or as soon as is reasonably possible for non-scheduled admissions

[1]Include for Choice Plus. [2]Include for Choice. ***[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]*** ***[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]***			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
(including Emergency admissions). In addition, for Non-Network Benefits you must notify us before the following services are received: intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home. If you fail to notify us as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[1]Include Network and Non-Network references for Choice Plus; delete references and the Non-Network row for Choice. *Limits will not apply to groups of 51+.* [Inpatient *Mental Health Services* are limited to [10 - 100] days per year.] [Outpatient *Mental Health Services* are limited to [10 - 100] visits per year.] [Non-Network Benefits for inpatient *Mental Health Services* are limited to [10 - 100] days per year.]	***[[1]Network]*** *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
[Non-Network Benefits for outpatient *Mental Health Services* are limited to [10 - 100] visits per year.] [Benefits for any combination of *Mental Health Services* described in this section and *Neurobiological Disorders* described below are limited as follows: • [10 - 100] days per year for inpatient *Mental Health Services* and *Neurobiological Disorders*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Neurobiological Disorders*.]]	*[Outpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.] [100% for visits for medication management]	[Yes] [No]	[Yes] [No]

[1]*Include for Choice Plus.* [2]*Include for Choice.*

[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]

[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Benefits for any combination of *Mental Health Services* described in this section and *Substance Use Disorder Services* described below are limited as follows: • [10 - 100] days per year for Inpatient *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Substance Use Disorder Services*.]]	***[[1]Non-Network]*** *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
[Benefits for any combination of *Mental Health Services* described in this section and *Neurobiological Disorders* and *Substance Use Disorder Services* described below are limited as follows: • [10 - 100] days per year for inpatient *Neurobiological Disorders, Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Neurobiological Disorders, Mental Health Services* and *Substance Use Disorder Services*.]] [Benefits for any inpatient and outpatient combination of *Autism Spectrum Disorder Services* described in this section are limited as follows: • [Limited to $50,000 in Eligible Expenses per year for *Autism*	*[Outpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.] [100% for visits for medication management]	[Yes] [No]	[Yes] [No]

[1]Include for Choice Plus. [2]Include for Choice.

[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]

[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Spectrum Disorder Services]			
Include for groups that purchase mental health benefits. **[#.] [Neurobiological Disorder Services] and [Autism Spectrum Disorder Services]**			
Do not include Pre-Service Notification Requirement for Choice. **[Pre-Service Notification Requirement]** [For Non-Network Benefits for a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), you must notify us prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must notify us before the following services are received: intensive outpatient program treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home [; Applied Behavioral Analysis]. If you fail to notify us as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[1]Include Network and Non-Network references for Choice Plus; delete references and the Non-Network row for Choice. *Limits will not apply to groups of 51+.* [Inpatient *Neurobiological Disorder Services* are limited to [10 - 100] days per year.] [Outpatient *Neurobiological Disorder Services* are limited to [10 - 100] visits per year.] [Non-Network Benefits for inpatient *Neurobiological Disorder Services* are limited to [10 - 100] days per year.]	***[[1]Network]*** *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
[Non-Network Benefits for outpatient *Neurobiological Disorder Services* are	*[Outpatient]* [[50 - 100]%]	[Yes] [No]	[Yes] [No]

[1]*Include for Choice Plus.* [2]*Include for Choice.*

[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]

[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
limited to [10 - 100] visits per year.] [Benefits for any combination of *Neurobiological Disorders Services* described in this section and *Mental Health Services* described above are limited as follows: • [10 - 100] days per year for inpatient *Neurobiological Disorder Services* and *Mental Health Services*. • [10 - 100] visits per year for outpatient *Neurobiological Disorder Services* and *Mental Health Services*.]] [Benefits for any inpatient and outpatient combination of *Autism Spectrum Disorder Services* described in this section are limited as follows: [Limited to $50,000 in Eligible Expenses per year for *Autism Spectrum Disorder Services*] [Benefits for any combination of *Neurobiological Disorder Services* described in this section, *Mental Health Services* described above and *Substance Use Disorder Services* described further below are limited as follows: • [10 - 100] days per year for inpatient *Neurobiological Disorder services, Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Neurobiological Disorder Services, Mental Health Services* and *Substance Use Disorder Services*.]]	[100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.] [100% for visits for medication management] ***[[1]Non-Network]*** *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]

[1]*Include for Choice Plus.* [2]*Include for Choice.*

[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]

[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Benefits for any inpatient and outpatient combination of *Autism Spectrum Disorder Services* described in this section are limited as follows: [Limited to $50,000 in Eligible Expenses per year for *Autism Spectrum Disorder Services*]	*[Outpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.] [100% for visits for medication management]	[Yes] [No]	[Yes] [No]
Include for groups that purchase substance use disorder benefits. **[#.] [Substance Use Disorder Services]**			
Do not include Pre-Service Notification Requirement for Choice. **[Pre-Service Notification Requirement]** [For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), you must notify us prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must notify us before the following services are received: Services requiring pre-service notification: intensive outpatient program treatment; psychological testing; outpatient treatment of opioid dependence; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home. If you fail to notify us as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[1]*Include Network and Non-Network references for Choice Plus; delete references and the Non-Network row for Choice.* *Limits will not apply to groups of 51+.* [Inpatient *Substance Use Disorder Services* are limited to [10 - 100] days per year.] [Outpatient *Substance Use Disorder*	***[[1]Network]*** *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 -	[Yes] [No]	[Yes] [No]

[1]*Include for Choice Plus.* [2]*Include for Choice.*

[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]

[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Services are limited to [10 - 100] visits per year.] [Non-Network Benefits for inpatient *Substance Use Disorder Services* are limited to [10 - 100] days per year.] [Non-Network Benefits for outpatient *Substance Use Disorder Services* are limited to [10 - 100] visits per year.] [Benefits for any combination of *Substance Use Disorder Services* described in this section and *Mental Health Services* described above are limited as follows: • [10 - 100] days per year for inpatient *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Substance Use Disorder Services*.]]	2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
[Benefits for any combination of *Substance Use Disorder Services* described in this section and *Mental Health Services* and *Neurobiological Disorders* described above are limited as follows: • [10 - 100] days per year for inpatient *Neurobiological Disorder Services,,Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Neurobiological Disorder Services, Mental Health Services* and *Substance Use Disorder Services*.]]	*[Outpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.] [100% for visits for medication management] ***[[1]Non-Network]*** *[Inpatient]*	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

[1]*Include for Choice Plus.* [2]*Include for Choice.*

[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]

[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
	[Outpatient] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.] [100% for visits for medication management]	[Yes] [No]	[Yes] [No]

Exclusions for *Mental Health, Neurobiological Disorders - Autism Spectrum Disorders* and *Substance Use Disorders* in the *Certificate* under *Section 2: Exclusions and Limitations* are deleted and replaced with the following:

[#] Mental Health

Introductory sentence and exclusions 1-9 apply when plan design includes benefits for mental health services.

Exclusion 10 applies when plan design does not include benefits for mental health services. Renumber exclusion to #1.

[Exclusions listed directly below apply to services described under *Mental Health Services* in *Section 1: Covered Health Services*.]

[1.] [Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[2.] [Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.]*

[3.] [Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.]

[4.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.]

[5.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]

[6.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.]

[7.] [Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[8.] [Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.]

[9.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.]

[1]Applies when the group provides benefits for mental health services under a separate plan.

[10.] [Services for the treatment of mental illness or mental health conditions [[1]that the Enrolling Group has elected to provide through a separate benefit plan].]

[#] Neurobiological Disorders - Autism Spectrum Disorders

Introductory sentence and exclusions 1-8 apply when plan design includes benefits for neurobiological disorder/autism spectrum disorder services.

Exclusion 9 applies when plan design does not include benefits for neurobiological disorder/autism spectrum disorder services. Renumber exclusion to #1.

[Exclusions listed directly below apply to services described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.]

[1.] [Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[2.] [Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.]

[3.] [Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[4.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.]

[5.] [Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.]

[6.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.]

Applies when plan design does not include benefits for expanded autism spectrum disorder.

[7.] [Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.]

[8.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.]

Applies when plan design does not include benefits for neurobiological disorder/autism spectrum disorder services.

[1]Applies when the group provides benefits for autism spectrum disorders under a separate plan.

[9.] [Services for the treatment of autism spectrum disorders as the primary diagnosis [[1]that the Enrolling Group has elected to provide through a separate benefit plan]. (Autism spectrum disorders are a group of neurobiological disorders that includes *Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder* and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS).*)]

[#] Substance Use Disorders

Introductory sentence and exclusions 1-4 apply when plan design includes benefits for substance use disorders services.

Exclusion 5 applies when plan design does not include benefits for substance use disorders services. Renumber exclusion to #1.

[Exclusions listed directly below apply to services described under *Substance Use Disorder Services* in *Section 1: Covered Health Services*.]

[1.] [Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[2.] [Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.]

[3.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]

[4.] [Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.]

Applies when plan does not include benefits for substance use disorders.

[1]Applies when the group provides benefits for substance use disorders under a separate plan.

[5.] [Services for the treatment of substance use disorder services [[1]that the Enrolling Group has elected to provide through a separate benefit plan].]

The definition of Intermediate Care is deleted.

Contract Issuance: *Include Effective Date only if Amendment is to be mailed separate from the COC. Do not include effective date when amendment is issued as part of the COC.*

[Effective Date of this Amendment: _____]

_____

(Name and Title)

SERFF Tracking Number:	*UHLC-127378273*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*49598*
Company Tracking Number:	*MHPAMD.H.09.AR_REV1*		
TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02G.003C Large Group Only - HMO*
Product Name:	*MHPAMD.H.09.AR_REV1*		
Project Name/Number:	*MHPAMD.H.09.AR_REV1/MHPAMD.H.09.AR_REV1*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	08/19/2011
Comments:			
Attachment:			
MHPAMD.H.09.AR_REV1 Compliance.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	08/19/2011
Bypass Reason:	Not Applicable. No Rates associated with the filing.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	08/19/2011
Bypass Reason:	Not Applicable. No Rates associated with the filing.		
Comments:			

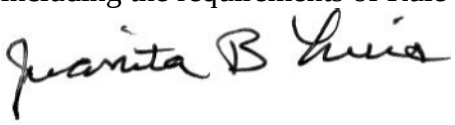
		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	08/19/2011
Bypass Reason:	Not Applicable. No Rates associated with the filing.		
Comments:			

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: UnitedHealthcare of Arkansas, Inc.

Form Number(s): MHPAMD.H.09.AR_REV1

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Juanita B Luis
Name

Assistant Secretary
Title

August 18, 2011
Date